



**PRE-SEDATION EVALUATION**

Patient Name:		Age:	<b>Allergies:</b> Include food, drug, latex <input type="checkbox"/> NKDA		
		Weight:                      kg			
Appointment	Procedure:	Pre-Procedure Diagnosis:			
Relevant History to explain the need for the procedure:					
Other Relevant Medical Conditions: <input type="checkbox"/> History of bleeding problems, Asthma, or BPD. If checked, provide details					
Previous Sedation History:					
Psychological Evaluation: <input type="checkbox"/> Normal for age					
If not normal for age, list concerns that explain the need for sedation or condition that may interfere with administration of sedative					
Recent Infectious Disease Exposure and Date: <input type="checkbox"/> None				Pregnancy Status: <input type="checkbox"/> N/A	
<b>Current Medications</b> <small>(Include OTC and/or illicit drugs)</small>			<b>Indicate ASA Physical Status Classification:</b> <input type="checkbox"/> Class 1: A normally healthy patient <input type="checkbox"/> Class 2: A patient with mild systemic disease <input type="checkbox"/> Class 3*: A patient with severe systemic disease <input type="checkbox"/> Class 4*: A patient with severe systemic disease that is constant threat to life <input type="checkbox"/> Class 5*: A moribund patient who is not expected to survive without the operation  *Please note if patient is <u>ASA 3 or higher</u> , <u>deep sedation must be done by an anesthesiologist or credentialed MD</u>		
Drug	Dose	Route			Time
If on <u>anti-seizure</u> medications: <input type="checkbox"/> Give the dose as scheduled <input type="checkbox"/> OK to hold the dose until after the test is done					
Relevant Physical Exam:	Normal ( <input type="checkbox"/> )	Describe Abnormal Findings			
HEENT					
Heart: Rhythm, Murmurs, etc.					
Lungs: Rales, Rhonchi					
Other PE Findings:					
Assessment:					
This is for physicians who are not members of the KMCWC Medical Staff and for any patient <i>ASA Class 3 or higher</i> . Send or fax consultation request form (Form # NC-5-539). <input type="checkbox"/> Consultation with anesthesiologist					
I have informed the patient/patient's responsible party of the: a) nature of the treatment/procedure recommended, b) risks/benefits of the sedation medication(s) involved in such treatment/procedure, c) alternative forms of treatment including non-treatment available, d) anticipated results of the treatment.					
Physician's Signature:			Date:		